MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

March 26, 2008
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, March 26, 2008 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Bob Atwater, Charlie Dannelly, James Forrester, Vernon Malone, and William Purcell and Representatives Martha Alexander, Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, Carolyn Justus, and Fred Steen. Advisory members Senator Larry Shaw, Representatives Van Braxton and William Brisson were present. Also in attendance were Representative Jennifer Weiss and Representative Deborah Ross.

Gann Watson, Shawn Parker, Ben Popkin, Andrea Poole, Denise Harb, Susan Barham, and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She asked for a motion to approve the minutes from the February 27, 2008 meeting. Representative Justus made the motion and the minutes were approved.

Representative Insko then asked Shawn Parker, Research Division, to review the information packet responding to questions asked by members during the February meetings.

Next, Denise Harb and Andrea Poole, Fiscal Research, reviewed the monthly MH/DD/SA system indicators report. (See Attachment No. 2) Ms. Harb explained that staff was working with the Department to obtain information showing the type of provider as requested by members at the last meeting. She said that information would be available at the April 17th meeting. The chart did indicate that if spending continued at the current rate, it would over spend the budget.

Representative Insko then welcomed Ramon Rojano, Area Director for Wake County Human Services, and Sharen Prevatte, Area Director for Southeastern Regional MH/DD/SA Services. Dr. Rojano reviewed a 9 point agenda of short and long term initiatives addressing the closure of Dorothea Dix hospital. (See Attachment No. 3) He told members about a contract with Holly Hill hospital making psychiatric beds available to Wake County patients, and temporary beds that would be available at Dorothea Dix. He said that Wake County was very excited about a 32-bed psychiatric facility to be completed in 3 years. He also said that Wake County was developing a greater crisis management system working with Rex Hospital, Wake Med and Duke hospitals. He said

that substance abuse and supportive housing continue to be great challenges. Addressing mental health reform, Dr. Rojano suggested that the State needed to conduct a sophisticated financial cost analysis of the whole system; to clarify the population being addressed; to create a well funded benefits package to attract staff; and to specifically address housing and substance abuse.

Sharen Prevatte from Southeastern Regional MH/DD/SA Services addressed the status of the LME. She said that in some respects the system was in disarray. She said the feeling of demoralized staff, whether the staff was with an LME or a provider, was one of the most difficult things to deal with. She said that staff had difficulty because things changed so quickly. Ms. Prevatte also said that too much LME and provider time was spent on the appeals process. She said that even though reform was challenging, there were also good things going on with reform. She said that Southeastern had been fortunate to have had a 40 year close relationship with the local in-patient system in the local hospital. The hospital has 33 beds that serve adults only but Southeastern is also in a partnership with two other programs. She said there was a mobile crisis team that was combined with the hospital activities, and located in a county building. She said there was also an 11 bed crisis stabilization facility that served MH, DD, and SA, children and adults. She explained the three together, along with the psychiatrists, made a wonderful system because they were all tied together making them a part of the LME system. She said psychiatrists were employed by Southeastern in order to serve more individuals, going to provider facilities, and providing psychiatric medical evaluations. Ms. Prevatte said the four counties worked collaboratively to address issues in each county. She added that one priority was to address the need of a child in-patient unit since there was not one in any of the four counties. Another goal she mentioned was to get more qualified staff in the provider community to treat substance abuse. She also said a crisis intervention team was needed. Ms. Prevatte said a stronger community system could be achieved with fewer changes in order to create stability.

Next, Andrea Poole and Shawn Parker reviewed the draft report of the LOC recommendations to the General Assembly. (See Attachment No. 4) Ms. Poole mentioned that under the State-Operated Services section, there were recommendations made that were based on reports that the committee had received or ideas talked about but not officially heard by the committee. She said that Housing 400 Initiative, Transitional Residential Treatment Options, and Suspension of Medicaid Eligibility would be heard today. She also mentioned that currently there was no appropriation amount included in the draft report. Mr. Parker explained that the draft before the committee was the staff's grasp from meetings held thus far, and comments from members. The actual report reflecting the committee's actual recommendations would be heard at the April 17th meeting.

Committee members discussed the possibility of staff meeting with LMEs, providers, and consumers in order to see that all of the issues and problems were being addressed. There was also much discussion regarding the delay of the expenditure of State funds for appropriated services. Ms. Poole explained that staff's difficulty is that they are hearing different information between the Department and the LMEs. Senator Nesbitt told staff to include the above explanation in the report. It was also suggested that the statement not

be included and that a consensus between all parties needed to be realized for the report. Members also requested a list of the 9 single-stream LMEs, a list of where the CAP programs were located, and a copy of the standards the Department would have in place for the LMEs to apply for single-stream. Mr. Parker said he would have the information available before the meeting adjourned.

Ms. Poole explained the committee requested an update on construction projects on a monthly basis. However, she said that staff had asked the Department to provide an update but the Department chose not to provide one to staff. Ms. Poole was able to provide a memo released on March 6th from Secretary Benton giving an update of the State operated psychiatric hospitals. (See Attachment No. 5) She added that the inspectors went to Broughton hospital on February 25th and indicated to CMS that the hospital was ready for re-inspection and would like to reapply. The inspectors arrived March 25th and were expected to be there through March 28th.

Trisch Amend, NC Housing Finance Agency and Julia Bick, Housing Coordinator for DHHS, addressed the Housing 400 Initiative. (See Attachment No. 6) They first reviewed the results of the two appropriations from the General Assembly for FY 2006-07 stating that 430 units had been financed across the State. Appropriations for FY 2007-08 resulted in 120 units becoming available shortly for people with DD, and 200-250 apartments would be integrated into the 2008 Housing Credit developments. They highlighted pertinent information in the interim report which was submitted March 1, 2008. Ms. Amend said that over 1,300 units had been funded, with 681 actually open and of those, 604 were occupied. Ms. Bick said the final report due March 1, 2009 would look at the most efficient use of resources to meet a range of needs. She added that the final report required additional research based on what has been found in other states, and academic research. The report will also focus on meeting the housing needs of those with substance abuse issues.

Next, Bonnie Morrell from the Division of MH/DD/SAS addressed transitional residential treatment options. (See report, Attachment No. 7) Dr. Morrell stated that there had been great concern with mixing younger individuals with mental illness, especially with behavior issues, in adult care homes with the elderly. She said the housing and residential resources available in the community were not designed for this population. A model was designed to set up a pilot effort to provide transitional residential treatment in a 6 bed group home setting in the community. The proposed definition and implementation has stringent admissions criteria, accepting those with multiple hospitalizations, recent in-patient stays, and those with lots of difficulties when returning to the community. She said it was believed that these individuals needed a highly structured, short-term residential treatment program. Staffing requirements was the key difference from other facilities. Dr. Morrell said the other key was to be sure it was transitional, with a maximum length of stay of no more than 6 months. During the last month before leaving the facility, a resident would make arrangements for housing, and begin working with a mental health treatment provider in the community. She suggested implementation as a pilot program since there was nothing like this in North Carolina. She said that new licensing rules would be needed, and the pilot would need funding but in the long range would cost less than hospitalization or a failed attempt to

return to the community. Depending on the funding, she said there could be 1, 2, or 3 models across the State. She said she believed it was the model that would begin to address the issue of those individuals who do not belong in adult care homes. Dr. Morrell was asked what the cost was for a bed at a State facility. The cost was $700 per day or $255,000 per year. She reminded members that the pilot would be treating 12 patients a year with the 6 month limit per individual. She added that a facility could be operational within 6 months of approval.

Tara Larson, Acting Deputy Director for Clinical Affairs, DMA, explained the two issues regarding the suspension of Medicaid eligibility. She said that one was when a person went into an institution of mental deficiency (IMD), for individuals between the ages of 20 and 64 Medicaid cannot be drawn down for that placement. The second reason is people that are incarcerated in prison or a county jail or children that are in custody of DJJDT. Federal requirements do not allow for Medicaid to be billed while a person is in the types of facilities mentioned. Eligibility was stopped as soon as DSS was notified. Problems developed when a consumer went into a facility for a short period of time. Ms. Larson said that DMA was proposing, within federal requirements, to no longer terminate Medicaid eligibility when a person goes into a facility. It would allow persons who enter a correctional facility or IMD to remain eligible in the Eligibility Information System (EIS) until the first re-determination and then terminate assistance. The EIS would require changes to show these persons are in one of these places so no covered services would be paid. DMA also proposes to ensure facilities are aware that discharge planners with IMDs or in prisons, can use mail-in applications to start the application process thirty days before the individual is released from the facility. She said DMA would work with the hospitals, the local DSS's, and the prisons, to make sure that they were aware that discharge planning needs are imminent, that Medicaid eligibility would need to be addressed, and could apply for eligibility within 30 days of discharge. Ms. Larson said this should address a large part of the problem, and that hopefully the day a person is discharged, they would have Medicaid eligibility.

Ms. Larson was asked how much discharge medication was provided. The Division responded that only 1-2 weeks was given because of budgetary reasons. Members felt this was not adequate, that a 30 day supply would be better to give a person ample opportunity to get on their feet. Jim Osberg, Division of MH/DD/SAS, added that this was more of an issue for the short term population. For the longer term population, discharge planning is usually sufficient to address what they need to become re-eligible, and that they did have the 30 day lead time. Ms. Wainwright added that care coordinators with the LMEs participate in the discharge planning, linking the consumer with the provider in the community insuring that medications are available. It was suggested that the burden should be on the hospitals to see that the patients had enough medication until they were able to obtain more. Ms. Larson said she would see if there was a way to look at applications for re-determination, keeping them suspended until the discharge date was known. She added that it was important to see that federal funds were not drawn down at the time. She said she would return with a recommendation.

After lunch, continuing with the draft recommendations, page 15, Denise Harb and Gann Watson from Bill Drafting gave a summary heard during the interim of services offered

in the community, and several factors that may have contributed to the problems specifically within community support. Ms. Harb said that problems were not limited to community support services but could make the system vulnerable to have similar problems in the future with other services. They reviewed each of the findings and suggested recommendations. Members were concerned that some recommendations were too vague and needed tightening up. Members agreed that a clear line of accountability was essential to community support. It was suggested that providers conduct background checks on employees with results available to LMEs and DHHS, and if results are questionable, then grounds for dismissal should be realized. It was also suggested that the Disabilities Rights of North Carolina organization be involved in the appeals process under consideration. Another suggestion was to make a long term plan and look at what is working, i.e., Mecklenburg crisis and PBH, and not recreate the wheel. Another suggested recommendation was to require that all LMEs in the State have the same IT system. Staff was directed to draft a proposal on IT systems, and to look back at issues raised to standardize the system and include them as recommendations. It was also suggested that the Institute of Medicine do a study of the transitioning of the developmental disability population as their parents' age, and look at moving CAP away from Value Options and back to the LMEs.

Continuing, Secretary Dempsey Benton from the Department of Health and Human Services presented a report on the Department's recommendations, and updated major issues. (See Attachment No. 8) Secretary Benton said he was recommending that all deaths at State operated facilities be reported to the Medical Examiner; that a workforce development strategy be formed to look at recruiting and retaining hospital staff; that a statewide mobile crisis service be within 30 minutes or 30 miles of all residents; that an additional 180 inpatient beds be contracted with hospitals and secured in the community; that providers have national accreditation within 3 years; that a 90 day appeals process be established; and that psychiatric services be available in every region or LME. Secretary Benton then reviewed the latest community support budget. He said that he hoped adjustments put into place earlier during the calendar year would produce a more favorable 4th quarter report. Secretary Benton was asked if the Department was looking at tiered rates. He responded that the Mercer Group had been retained to look at the community support package including the service definitions within the existing authorization. He said they would also be looking at the rates, and if the Department needed to move to the differentiated rate.

There being no further business, the meeting adjourned at 3:45 PM.

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Senator Martin Nesbitt, Co-Chair Representative Verla Insko, Co-Chair

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Rennie Hobby, Committee Assistant